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We Got This and We Don't: Pediatricians Going to Battle for the "Big Children" of COVID-19

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I RECENTLY FINISHED my last "tour" as the service attending on an adult COVID (coronavirus disease) unit. I'm a pediatric hospitalist. I've begun calling these service weeks "tours," because our everyday work really does feel like a battle against the virus. And to fight this battle, we've needed to band together, across departments, across disciplines, in a way I've never experienced before. It's inspiring yet terrifying that it's necessary.

Entering my first week as ward attending for adult COVID patients, I was uncomfortable. The last time I cared for adult patients was nearly 15 years ago, and adults are not just "big children," to flip our common saying in the pediatric world. I was also anxious and sad, knowing I'd be away from my family, my husband, and our 2 school-aged children, for 2 weeks in self-quarantine, both during this service week and for an additional week afterward, to monitor for potential development of COVID symptoms. This was not normal.

But my first day on the unit, I was surprised by how normal it felt. Well, normal other than the fact that an adult patient left against medical advice and the process involved the mere signing of a piece of paper. I was amazed by how much my presence on a medical team, now surrounded by mostly internal medicine learners, was therapeutic for me. It provided some semblance of routine, a system to my day that had been otherwise lacking in my recently upside down home life, trying to homeschool my children while also working via many video conference calls. I got to be within 6 feet of people who were not in my family again and practice an art that I love. In some ways, this felt less stressful than home.

As my time on the unit continued, I quickly discovered that pediatric skills are highly relevant on this battleground. As a pediatric hospitalist, I care for patients with respiratory viruses "all the time." I learned a long time ago to observe my patient's work of breathing and vital signs to determine if I'm worried or not worried, and thank goodness, because identifying crackles using a disposable stethoscope and a noisy powered air-purifying respirator is nearly impossible. Discerning an adult decompensating due to COVID was eerily similar to discerning the infant on the brink of respiratory failure during RSV (respiratory syncytial virus) season. I got this. Did I get all the intricacies of my patients' antihypertensive medications and how each medication may affect heart function? No. But I was not alone in the care of my patients. I was working among a team of highly capable and knowledgeable internal medicine trainees, with an internal medicine attending physician working right down the hall. We were collectively caring for our patients, with our individual knowledge piecing together to complete the larger jigsaw puzzle. I quickly learned to "phone a friend" for non-COVID-related issues that I was not going to master in such a short period of time.

Whether working on a COVID floor, in the intensive care unit (ICU), or in a community hospital, many of my colleagues have impressively and seamlessly assumed care of adult patients, sharing similar sentiments parlaying their pediatric experience into adult management. One of my pediatric intensive care unit (PICU) colleagues expressed that our pediatric mindset, always beginning care with the assumption that our patients are too young to die, even our sickest of sick patients, and the attention to minute details that accompanies the medical care of infants and children, has translated well into the care of adult COVID patients. She recalled 1 patient whom she accepted from the emergency department to the converted PICU as her third COVID positive adult in respiratory failure during a single overnight shift. But when reviewing this patient's data through her pediatric intensivist lens, things didn't add up. The x-ray didn't look bad enough; the degree of hypoxia was too severe. She phoned her medical ICU colleague and they quickly determined that this patient had a critical pulmonary embolism.

Beyond the medicine, our pediatric communication skills are also powerful on the COVID battleground. Pediatricians must learn to assess both verbal and nonverbal communication. Many have learned to be magicians who can calm a hospitalized toddler, fearful and in pain in a foreign environment, or can help to comfort parents who are frightened for their child and physically exhausted. One pediatric colleague described this as the "gentle disposition" of pediatricians, expressing how useful this skill was when discussing sensitive topics with anxious family members via phone regarding her adult ICU patients' care. Through my years of pediatric practice, I've adopted a technique in which I wear a big smile while communicating in a goofy or exaggerated way to make even the most apprehensive hospitalized child smile. I used this technique often during this pandemic, for 1 adult patient in particular who was fearful and sad being away from her family, and embarrassed that she could never remember my name as she recovered from ICU delirium; I would laugh and act overdramatically insulted, and her therapeutic laugh would soon follow mine. I also found I could silently identify other team members who were feeling upset and uncomfortable, and make quick adjustments to help. At the end of our virtual orientation prior to starting service on the COVID unit, I looked at the uncertainty on the faces of the other attending physicians and residents on the video call, channeled my inner cheerleader and said, "go peds!" This evolved into our naming the teams after pediatric themes and our favorite international sports teams. Senior leaders later remarked that my simple gesture had instilled a spirit of enthusiasm and confidence that carried forward even to subsequent teams.

I wish I could say that the transition from pediatric to adult care was easy and that all of our pediatric skills served us well, but that's not true. My PICU colleague, while describing the optimistic pediatric mindset, also expressed how easily it could become a weakness in the care of COVID positive adults. We weren't prepared for the cruel new reality of rapid decline and potential for mortality. When caring for pediatric ICU patients, my colleague described the incredible rarity of an unanticipated cardiopulmonary arrest; pre-COVID she could count on one hand the number of times she had witnessed such an event in her career. Unfortunately, this is one area where adults really are not just "big children," and she felt as if an arrest might be lurking around every corner as the unit filled up with very sick COVID positive adults.

I also discovered I had a similar weakness: provision of comfort measures only. While my pediatric communication skills may have helped me facilitate the difficult conversations during which families decided to pursue "comfort care" for their loved ones in preparation for death, beneath the surface, I wanted to crawl out of my skin. I'm not accustomed to accepting the inevitability of death for my patients. Hospital visitation restrictions during COVID-19 only compounded matters further, making it impossible for groups of family members to gather around their loved ones, comforting the patient and each other, during these vulnerable final moments in life. It felt so wrong, and I became emotional. I found myself sitting at a patient's bedside, tears forming inside my powered air-purifying respirator, holding his hand because his family member could not be there. These are the types of patient memories that I know will stay with me forever.

However, as we move on from adult care back to our pediatric duties, my colleagues and I will carry forward our positive experiences. We've shed a powerful light on our strengths as pediatricians. We've built transdepartmental relationships that will not disappear with the eradication of the virus. My community-based colleague described this as the breaking down of "hospital silos," a silver lining to COVID-19, creating an environment of greater collaboration that will carry forward into nonpandemic times. My PICU colleagues recognize that the knowledge they've gained in caring for adults has strengthened them as physicians, and they will continue to draw on the relationships they've formed with their adult ICU counterparts when the physiologies or the age of their patients overlap. I hope we can remember and retain the camaraderie, cooperation, and encouragement that have transformed even the physical appearance of the hospital. The adult medical center now looks like a children's hospital, covered in colorful construction paper hearts with positive messages on them. The one right next to the door handle for our team's workroom on the COVID unit said, "we got this." Yes, we do.

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